COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. BUTCH OTTER – Governor
RICHARD ARMSTRONG – Director

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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PHONE 208-334-6626
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July 15, 2009

Renee Naylor
Preferred Community Homes Milliken
7091 West Emerald Street
Boise, Idaho 83704

RE: Preferred Community Homes Milliken, provider #13G053

Dear Ms. Naylor:

On July 8, 2009, a follow-up visit of your facility was conducted to verify corrections of deficiencies noted during the survey of May 5, 2009.

We were able to determine that the Condition of Participation on Client Protection (42 CFR 483.420), Facility Staffing (42 CFR 483.430) and Client Behavior & Facility Practices (42 CFR 483.450) are now met.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed, along with a full ICF/MR license. This license is effective through December 31, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **July 28, 2009**, and keep a copy for your records.

Thank you for the courtesies extended to the surveyors during their visit. If we can be of any help to you, please call us at (208) 334-6626.

Sincerely,

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

NW/mlw

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G053	A. BUILDING _____ B. WING _____	R 07/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - MILLIKEN	7904 ARLINGTON DRIVE NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS The following deficiencies were cited during the follow-up survey. The survey was conducted by: Monica Williams, QMRP, Team Leader Matt Hauser, QMRP Common abbreviations used in this report are: ADHD - Attention Deficit Hyperactive Disorder AQ - Assistant Qualified Mental Retardation Professional CFA - Comprehensive Functional Assessment IPP - Individual Program Plan NOS - Not Otherwise Specified PTSD - Post Traumatic Stress Disorder QMRP - Qualified Mental Retardation Professional RSC - Resident Service Coordinator	{W 000}	Preparation and implementation of this plan of corrections does not constitute admission or agreement by Milliken Heights with the facts, findings, or other statements as alleged by the State agency dated July 08, 2009. Submission of this plan of correction is required by law and does not evidence the truth of any of the findings as stated by the survey agency. Milliken Heights specifically reserves the right to move to strike or exclude this doeument as evidence in any civil, criminal or administrative action.	
W 135	483.420(a)(10) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans. This STANDARD is not met as evidenced by: Based on observation, record review, and individual and staff interviews, it was determined the facility failed to ensure individuals had access to telephones with privacy for incoming and outgoing local and long distance calls for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in a lack of privacy for individuals using the telephone. The findings	W 135	**W135 483.420(a)(10) PROTECTION OF CLIENTS RIGHTS** We are placing a phone in the office and informing all individuals and staff of availability of phone for privacy upon request. This will allow them the choice for privacy. We will be including this in staff training and documentation. A key to the office will be available at all times to the staff. A key/call log will be kept for Administrator review to monitor that choice of privacy was offered to all individuals. Person Responsible: Administrator Monitored: Monthly Completion date: 08/05/2009 RECEIVED JUL 29 2009 FACILITY STANDARD	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rusty Simmons | TITLE: Administrator | (X6) DATE: 7/28/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 135	Continued From page 1 include: 1. The facility housed six males, age 15 to 19, all of whom had sexually inappropriate behavior. Additionally, 4 of those individuals (Individuals #2 - #5) engaged in suicidal threats. An observation was conducted on 7/6/09 from 2:10 - 4:50 p.m. During that time, Individual #4 was interviewed and stated his telephone calls were monitored by staff and he did not like it. Individual #4's IPP, dated 2/25/09, documented that Individual #4's phone calls were monitored by staff because of ongoing calls to a "girlfriend." The parents of the said "girlfriend" threatened to file harassment charges against Individual #4 if the phone calls did not stop. During the observation, Individuals #1, #2, and #6 were willing to be interviewed. When asked, the individuals stated the only accessible telephone in the facility was located in the kitchen. Individual #2 stated if he wanted privacy while on the phone, he had to whisper. The individuals stated they understood the need for staff supervision and monitoring but they could hear each others' phone conversations. It was verified, during the above noted observation, that the only phone in the facility was located in the kitchen. When asked, the AQ and Administrator both stated during an interview on 7/8/09 from 1:37 - 2:35 p.m., ensuring privacy during telephone calls was an oversight and needed to be addressed for all individuals. The facility failed to ensure the right to privacy was upheld for Individuals #1 - #6.	W 135		
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION	W 250		

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W 250	Continued From page 2 The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on observation, record review, and individual and staff interviews it was determined the facility failed to develop active treatment schedules sufficient to direct staff for 3 of 3 individuals (Individuals #1 - #3) whose active treatment schedules were reviewed. Failure to ensure schedules were sufficient and flexible enough to direct staff in their efforts to address individuals' active treatment needs had the potential to impede their ability to provide such services to them. The findings include: 1. An observation was conducted on 7/6/09 from 10:55 a.m. - 12:20 p.m. During that time, Individuals #1 - #6 were noted to be in the facility. When asked what they were doing for the day, Individual #2 stated they were going fishing "again." Individual #2 stated they went fishing everyday and he was tired of it. Active Treatment Schedules were reviewed for Individuals #1 - #3. The schedules showed that the individuals were to be in school on weekdays. When asked, present staff stated they were following the weekend schedules as school was out for the summer. The weekend schedules were reviewed for Individuals #1 - #3. The schedules showed they were identical to each other and did not contain	W 250	**W250 483.440 (d)(2) PROGRAM IMPLEMENTATION** An activity calendar will be implemented in the home. Active treatment schedules are being revised for all individuals. Upon implementation they will be revised monthly by AQMRP and reviewed quarterly by QMRP to ensure this deficiency does not arise again. Person Responsible: AQMRP/QMRP Monitored: Monthly/ Quarterly Completion date: 09/08/2009	

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W 250	Continued From page 3 formal training objectives, informal training objectives, service objectives, and individuals' likes and dislikes. When asked, the RSC, who was present during the above noted observation, stated the schedules were "cookie cutter" and needed to be individualized. When asked, the AQ and Administrator both stated during an interview on 7/8/09 from 1:37 - 2:35 p.m., they were in process of revising all individuals' active treatment schedules. The facility failed to ensure adequate active treatment schedules were developed for Individuals #1 - #3.	W 250		
W 260	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure individuals' IPPs accurately reflected and responded to the individuals' needs for 3 of 3 individuals (Individuals #1 - #3) whose IPPs were reviewed. This resulted in individuals' IPPs not being revised to reflect their current needs and status. The findings include: 1. Individual #1's IPP, dated 6/3/08, documented a 15 year old male diagnosed with mild mental retardation, Asperger's Syndrome, and ADHD. Individual #1's records were reviewed and showed multiple inconsistencies. When asked,	W 260	**W260 483.440(f)(2) PROGRAM MONITORING & CHANGE** For all individuals addendums to current IPP's are being completed to ensure data being collected is the correct objective on both programs & IPP until completion of new programming. New CFAs, review of annual assessments, IPPs, & programming are in the process of being completed for all individuals. Will put new system into place to continue to use with each individual upon admittance to Milliken Heights. Quarterly book audits will be done by QMRP and Administrator to ensure continuance of updated programming. Quarterly floor book audits will be completed by AQMRP as well to ensure floor books are cohesive with data in Q books. Person Responsible: QMRP Monitored: Monthly Completion date: 09/08/2009	

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W 260	Continued From page 4 the AQ and Administrator both stated during an interview on 7/8/09 from 1:37 - 2:35 p.m., they were aware of the inconsistencies and were in process of revising Individual #1's IPP. Examples included, but were not limited to, the following: a. His floor book (used by direct care staff) in the facility contained an IPP dated 6/3/08. However, the corresponding training programs, dated 5/1/09, did not match the objectives in the floor book IPP. His record at the company office contained a second IPP, dated 6/3/08 and revised 2/1/09. The objectives in the office IPP did not match the objectives in the floor book IPP. Additionally, the corresponding training programs in the office were dated 6/3/08 and did not match the objectives in the office IPP or the training programs in the facility. b. His QMRP Tracking Forms, dated 6/08 through 2/09, were not reflective of his current training objectives and status. The Tracking Forms listed training objectives from 2007. There were no entries since 2/09. The Tracking Forms were not updated to reflect his current training objectives and status. c. Both IPPs (floor book and office) contained training objectives that were inconsistent with his 6/6/07 CFA. For example his CFA documented he was independent with dressing. However, both IPPs contained objectives related to dressing.	W 260		

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W 260	Continued From page 5 d. Both IPPs (floor book and office) documented his physical therapy need was to participate in one hour of physical exercise, of his choice, each day. However, his Physical Therapy program from the floor book and office, dated 6/3/08, included knee extensions and side-lying hip abduction exercises. The facility failed to ensure Individual #1's IPP and corresponding programs were accurately revised at the facility and the office. Additionally, the facility failed to ensure his IPP was revised to ensure consistency with his CFA and physical therapy evaluation. The facility also failed to ensure his IPP was revised to reflect his current training objectives and status on his Tracking Forms. 2. Individual #2's IPP, dated 4/22/09, documented a 15 year old male diagnosed with mild mental retardation, pervasive developmental disorder, reactive attachment disorder, mood disorder NOS, PTSD, and Asperger's Syndrome. Individual #2's records were reviewed and showed multiple inconsistencies. When asked, the AQ and Administrator both stated during an interview on 7/8/09 from 1:37 - 2:35 p.m., they were aware of the inconsistencies and were in process of revising Individual #2's IPP. Examples included, but were not limited to, the following: a. His record contained a Psychosocial Risk Assessment, dated 5/28/09, which included 10 recommendations related to sexually inappropriate behavior, learning appropriate boundaries, and stealing from others. It was not	W 260		

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W 260	Continued From page 6 evident his IPP was updated to include the recommendations. b. His IPP documented his physical therapy need was to participate in one hour of physical exercise each day and he had no occupational therapy needs. However, his IPP contained related service objectives which stated he was to complete his physical therapy and occupational therapy "as needed or recommended." c. His IPP contained training objectives that were inconsistent with his 4/1/09 CFA. For example, his IPP included a training objective related to using a mouth retainer. There was no mention of a retainer anywhere else in the IPP and it was not identified as a need in his CFA. d. His record at the company office contained two IPPs, both dated 4/22/09. However, the IPPs contained different diagnoses. The facility failed to ensure Individual #2's IPP was revised to include recommendations from his Psychosocial Risk Assessment. Additionally, the facility failed to ensure his IPP was revised to ensure consistency with his CFA and physical and occupational therapy evaluations. The facility also failed to ensure both of his IPPs were consistent. 3. Individual #3's IPP, dated 12/17/08, documented a 17 year old male diagnosed with mild mental retardation, major depressive disorder, oppositional deficient disorder, and bipolar disorder. Individual #3's records were reviewed and showed multiple inconsistencies. When asked,	W 260		

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W 260	Continued From page 7 the AQ and Administrator both stated during an interview on 7/8/09 from 1:37 - 2:35 p.m., they were aware of the inconsistencies and were in process of revising Individual #3's IPP. Examples included, but were not limited to, the following: a. His record contained a Psychosocial Risk Assessment, dated 6/10/09, which included recommendations related to sexually inappropriate behavior, learning appropriate boundaries, and appropriate social interaction. Additionally, the Psychosocial Risk Assessment stated Individual #3 had a history of suicidal ideation related to his depression. The Assessment recommended a training program be developed to teach Individual #3 how to cope with the symptoms of depression. An IPP addendum, dated 3/23/09, stated symptoms would be monitored and tracked. However, the IPP was not updated to include an objective related to depression. b. His IPP contained training objectives that were inconsistent with his 12/10/08 CFA. For example, his IPP included a training objective (listed under the domain titled Self Administration of Medication) which was related to tracking weekly behaviors. However, his CFA showed he required assistance to identify his medications, state their times, identify their side effects, and identify the correct time of administration. His IPP contained an objective related to washing his face. However, his CFA documented he was independent with the task. c. His QMRP Tracking Forms did not contain	W 260		

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W 260	Continued From page 8 entries since 3/09. The Tracking Forms were not updated to reflect his current training objectives and status. The facility failed to ensure Individual #3's IPP was revised to include recommendations from his Psychosocial Risk Assessment. Additionally, the facility failed to ensure his IPP was revised to ensure consistency with his CFA. The facility also failed to ensure his IPP was revised to reflect his current training objectives and status on his Tracking Forms. The facility failed to ensure IPPs for Individuals #1 - #3 were revised to reflect their current needs and status.	W 260		
{W 312}	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of the individuals' IPPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 2 of 3 individuals (Individuals #1 and #2) whose medication reduction plans were reviewed. This resulted in individuals receiving behavior modifying drugs without plans that identified the drugs usage and how they may change in relation	{W 312}	**W312 483.450(e)(2) DRUG USAGE** **Medication reduction plans are being revised for all individuals. Behavior modification plans are in process of being written to monitor progression/ regression and generate a baseline and data for medication reduction plans. Monthly behavior meetings with the nurse, behavior specialist & AQMRP/ QMRP will be implemented to ensure continuing updates & discussion to prevent this deficiency in the future.** **Person Responsible: QMRP** **Monitored: Monthly** **Completion date: 09/08/2009**	

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{W 312}	Continued From page 9 to progress or regression. The findings include: 1. Individual #2's IPP, dated 4/22/09, documented a 15 year old male diagnosed with pervasive developmental disorder NOS, reactive attachment disorder, mood disorder NOS, PTSD, and Asperger's Syndrome. Individual #2's Medication Reduction Plan, dated 4/1/09, documented he received Trazodone (an anti-depressant drug) 200 mg for insomnia. However, there was no objective criteria related to the drug. Additionally, his IPP did not contain an objective related to insomnia. When asked, the AQ and Administrator both stated during an interview on 7/8/09 from 1:37 - 2:35 p.m., Individual #2's Medication Reduction Plan and IPP needed to be revised. 2. Individual #1's IPP, dated 6/3/08, documented a 15 year old male diagnosed with mild mental retardation, Asperger's Syndrome, and ADHD. Individual #1's Medication Reduction Plan, dated 4/22/08, documented he received Melatonin (an herbal drug) 3 mg each night for sleep. The Plan stated the criteria for reducing Melatonin was "5 or less episodes of sleep loss (less than 8 hours) per month for 3 months." However, Individual #1's IPP did not include a plan to assist him to improve sleep without the use of Melatonin. When asked, the AQ and Administrator both stated during an interview on 7/8/09 from 1:37 - 2:35 p.m., a plan needed to be developed for Individual #1.	{W 312}		

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{W 312}	Continued From page 10 The facility failed to ensure Medication Reduction Plans were adequately developed for Individuals #1 and #2. Repeat deficiency.	{W 312}		

Bureau of Facility Standards

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{MM197}	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312.	{MM197}	MM 197 16.03.11.075.10 (d) Written Plans Refer to POC for W312	
MM207	16.03.11.075.13 Freedom of Association Freedom of Association. Each resident admitted to the facility must be permitted to associate and communicate privately with persons of his choice, and to participate in activities of social, religious, and community groups at his discretion, unless medically contraindicated as documented by his physician in his medical record. This Rule is not met as evidenced by: Refer to W135.	MM207	MM207 16.03.11.075.13 Freedom of Association Refer to POC for W135	
MM238	16.03.11.080.03(h) Access to Resident's Records To be given access to all of the resident's records that pertain to his active treatment, subject to the requirements specified in Idaho Department of Health and Welfare Rules, Section 05.01.300 through Subsection 05.01.301,06, and Sections 05.01.310 through 05.01.339, "Rules Governing Protection and Disclosure of Department Records." This Rule is not met as evidenced by: Refer to W250.	MM238	MM238 16.03.11.080.03(h) Access to Resident's Records Refer to POC for W250	
MM861	16.03.11.270.08(f)(iii) Periodic Review Initiating periodic review of each individual plan of care for necessary modifications or adjustments.	MM861	MM861 16.03.11.270.08(f)(iii) Periodic Review Refer to POC for W260	

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FACILITY STANDARDS

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/28/09

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G053	A. BUILDING _____ B. WING _____	R 07/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - MILLIKEN	7904 ARLINGTON DRIVE NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM861	Continued From page 1 This Rule is not met as evidenced by: Refer to W260.	MM861		